CENTERSTON	WIEDICINE & WEDIC	THE SERVICES					15 110: 0700 0071	
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			01	COMPI	LETED	
		155029	A. BUI	A. BUILDING			05/02/2011	
		100029	B. WIN	IG		03/02/2	.011	
			•	STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIEF	K		5600 F	AST 16TH STREET			
COMMIN	COMMUNITY NURSING AND REHABILITATION CENTER				NAPOLIS, IN46218			
COMMONT I NORSING AND REHABILITATION CENTER			INDIA	NAI OLIS, IN40210				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
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K0000								
	A Life Safety Co	ode Recertification and	K(0000				
	State Licensure	Survey was conducted by						
		•						
		e Department of Health in						
	accordance with	42 CFR 483.70(a).						
	Survey Date: 05	5/02/11						
	Survey Date. 03	0/02/11						
	Facility Number	: 000012						
	Provider Numbe							
	AIM Number: 1	100274900						
	Surveyor: Mark	Caraher, Life Safety						
	_	Curanor, Erro Suroty						
	Code Specialist							
	At this Life Safe	ety Code survey.						
		rsing and Rehabilitation						
	-	_						
	Center was foun	d not in compliance with						
	Requirements fo	or Participation in						
	Medicare/Medic	eaid, 42 CFR Subpart						
		•						
		Safety from Fire and the						
	2000 Edition of	the National Fire						
	Protection Assoc	ciation (NFPA) 101, Life						
		SC), Chapter 19, Existing						
	,							
	Health Care Occ	cupancies and 410 IAC						
	16.2.							
	This two stars f	acility was determined to						
	-	acility was determined to						
	be of Type II (11	(1) construction and fully						
	sprinklered. The	e facility has a fire alarm						
	•	-						
	_	oke detection in the						
	corridors, areas	open to the corridors and						
	all resident sleer	oing rooms. The facility						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VS5Z21

Facility ID:

000012

TITLE

If continuation sheet

enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure the kitchen 1 of 1 rolling fire doors in the opening between the kitchen and the first floor Main Dining room is held open only by a device arranged to automatically close upon activation of the fire alarm system. This	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	VIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2)		(X3) DATE SURVEY		
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residents found to have been affected by the deficient practice? The entry door to the main dining room has a positive latching mechanism in order for the door set to latch to the frame.					-1			03/2//2011
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deficient practice could affect all How will you identify other		deficient practice	e could affect all	1		now will you lucifully other	'	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIHIT	MIC	01	COMPLE	TED
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COMMU	NITY NURSING AN	D REHABILITATION CENTER		INDIAN	APOLIS, IN46218		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	residents staff a	nd visitors in the vicinity			residents having the potent	ial	
	of the first floor Main Dining room.				to be affected by the same		
	of the first floor	Main Dining 100m.			deficient practice and what		
					corrective action will be tak		
	Findings include:				All residents have the poter	I .	
					to be affected by the alleged		
	Based on observ	ation with the			deficient practice. What		
					measures will be put into p	lace	
		rector during a tour of the			or what systemic changes v		
		30 a.m. to 1:00 p.m. on			you make to ensure that the		
	05/02/11, the kitchen adjoins the first				deficient practice does not		
	floor Main Dining room and a serving				recur? Maintenance Directo	or	
	window from the adjoining kitchen has a				has been in-serviced on assu	I .	
	rolling fire door equipped with a fusible				that all doors acting as a bar	- 1	
	I -				between a room and a corrid		
	link. The servin	g window rolling fire			must separate the two (2) by		
	door does not cle	ose upon activation of the			having a positive latching		
	fire alarm systen	n. The Main Dining room			mechanism to the door frame	e.	
	I	d from the corridor			Director of Maintenance or		
	_	y door set lacked a			designee will make rounds		
					weekly x 4 and then monthly		
	ı ^	mechanism for the doors			thereafter to ensure all exit		
	and the door set	did not latch into the			components latch to the		
	frame. Based or	interview at the time of			doorframe. How the correct	I .	
	observation the	Maintenance Director			action(s) will be monitored		
	· ·	ne first floor Main Dining			ensure the deficient practic		
	-				will not recur, i.e., what qua	- 1	
	1	set was not provided with			assurance program will be	•	
	positive latching	hardware and the rolling			into place? The CQI commi		
	fire door does no	ot close automatically			will review the results of the		
		of the fire alarm system.			component rounds conducte	d by	
					the Director of		
	2.1.10(1)				Maintenance/designee for		
	3.1-19(b)				compliance. If compliance is		
					achieved, an action plan will		
					developed to ensure complia	ince.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	01	COMPL	ETED
		155029	B. WING			05/02/2	011
			'		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			5600 EA	AST 16TH STREET		
	NITY NURSING AN	D REHABILITATION CENTER			APOLIS, IN46218		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
K0025 SS=E	least a one half hor accordance with 8 terminate at an atriprotected by fire-raglass panels and situo separate compeach floor. Dampe penetrations of sm heating, ventilating systems. 19.3.7 19.1.6.4 Based on observational facility failed to one of 2 smoke barrier. LSC Sections passage of building as pipe, cable or that the space best item and the smowith a material cassmoke resistance be protected by a designed for the deficient practice staff and visitors smoke barrier do smoke from a fire protective barrier.	:	К00	025	What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice? The twelve (12) in square opening in the smoke barrier wall set by room 216 is stopped to ensure that the opening is not exposed. Howill you identify other resid having the potential to be affected by the same deficie practice and what corrective action will be taken? All residents have the potential that affected by the alleged deficie practice. What measures we be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance staff we in-serviced on assuring any openings through smoke bar must be maintained to provide hour smoke residence. Maintenance Director will maintenance of the service of the s	en nch eis fire w ents ent e to be ent dill as	05/27/2011
	Based on observa	ation with the ector during a tour of the			rounds to check all smoke barriers weekly x 4 and then		

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000012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A DULL DING 01 COMPLETED			
ANDILAN	or connection	155029	A. BUILDING		05/02/2011
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER			AST 16TH STREET	
COMMU	NITY NURSING AN	D REHABILITATION CENTER	INDIAN	APOLIS, IN46218	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	TE COMPLETION DATE	
	05/02/11, the smoth the smoke barrier had one, twelve in the smoke barrier firestopped exposion interview at the Maintenance the twelve inch samoke barrier was smoke barrier do	30 a.m. to 1:00 p.m. on oke barrier wall above of door set by Room 216 anch square opening in the wall which was not sing the opening. Based the time of observation, and Director acknowledged quare opening in the all above the ceiling at the or set by Room 216 is which exposed the		monthly thereafter to ensure corridors are maintained. H will the corrective action(s) monitored to ensure the deficient practice will not re i.e., what quality assurance program will be put into place? The CQI committee review the results of the smo barriers for compliance. If compliance is not achieved, action plan will be developed ensure compliance.	be ecur, will oke
K0038 SS=E	readily accessible with section 7.1. Based on observation facility failed to degress through 3 egress locks was residents, staff ar 7.2.1.6.1, Delaye approved, listed, be installed on degressible ordinary hazard or protected through supervised autom	nged so that exits are at all times in accordance 19.2.1 ation and interview, the ensure the means of of 6 first floor delayed readily accessible for ad visitors. LSC d Egress Locks, allows delayed egress locks to cors serving low and contents in buildings nout by an approved, natic fire detection system dance with Section 9.6,	K0038	What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice? The front entranced door, the main dining room end door, and the West emergen personnel exit door will each release their locks within 15 seconds of application of for How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taken	en e exit exit ccy ce.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155029 05/02/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5600 EAST 16TH STREET COMMUNITY NURSING AND REHABILITATION CENTER INDIANAPOLIS, IN46218 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE All residents have the potential or an approved, supervised automatic to be affected by the alleged sprinkler system installed in accordance deficient practice. What with Section 9.7, and where permitted in measures will be put into place Chapters 12 through 42, provided: or what systemic changes will (a) The doors unlock upon actuation of an you make to ensure that the approved, supervised automatic sprinkler deficient practice does not recur? Maintenance staff was system installed in accordance with in-serviced on assuring all doors Section 9.7, or upon the actuation of any equipped with delayed egress heat detector or not more than two smoke locks are readily accessible for residents, staff and visitors. detectors of an approved, supervised Maintenance staff will test all automatic fire detection system installed doors equipped with delayed in accordance with Section 9.6. egress locks weekly x 4 and (b) The doors unlock upon loss of power monthly thereafter to assure locks controlling the lock or locking will release within fifteen 15 seconds of applying force. How mechanism. will the corrective action(s) be (c) An irreversible process shall release monitored to ensure the the lock within 15 seconds upon deficient practice will not recur, application of a force to the release device i.e., what quality assurance required in 7.2.1.5.4 that shall not be program will be put into place? The CQI committee will review required to exceed 15 lbf nor required to the results of the egress locks be continuously applied for more than 3 conducted by the Director of seconds. The initiation of the release Maintenance for compliance. If process shall activate an audible signal in compliance is not achieved, an action plan will be developed to the vicinity of the door. Once the door ensure compliance. lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less that 1 inch high and at least 1/8 inch in stroke width

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029		(X2) MULTIPI A. BUILDING B. WING	E CON	01	(X3) DATE S COMPL 05/02/2	ETED		
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5600 EAST 16TH STREET INDIANAPOLIS, IN46218					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	on a contrasting "PUSH UNTIL A DOOR CAN BE SECONDS". This deficient proposed for the proposed for the main dining of the main d	background that reads: ALARM SOUNDS. OPENED IN 15 actice could affect any visitor needing to exit the front entrance exit door, room exit door and the personnel exit door.						
	05/02/11, the fromain dining roor emergency personan adjacent sign ALARM SOUND OPENED IN 15 addition, the fromain dining roor emergency personal equipped with deach of these throrelease when the for more than fiff interview at the total Maintenance Direction of the second front entrance expenses of the second front entrance expenses and the second entrance expenses and	nt entrance exit door, the n exit door and the West nnel exit door each have stating "PUSH UNTIL DS. DOOR CAN BE						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/02/2011
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER	5600 E	ADDRESS, CITY, STATE, ZIP CODE AST 16TH STREET APOLIS, IN46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K0050 SS=F	the door handle varifteen seconds. 3.1-19(b) Fire drills are held varying conditions shift. The staff is the saware that drills routine. Responsi conducting drills is	at unexpected times under, at least quarterly on each familiar with procedures and are part of established bility for planning and assigned only to s who are qualified to			
	exercise leadershiconducted between announcement manaudible alarms. 1. Based on reconstruction of 4 quarters. The affects all occupation including resident Findings include Based on review Report" document Maintenance Dir 11:30 a.m. on 05 documentation occupation of the quarter in 2010.	p. Where drills are in 9 PM and 6 AM a coded ay be used instead of 19.7.1.2 ord review and interview, I to ensure fire drills were orly on the third shift for 1 his deficient practice ants in the facility hts, staff and visitors.	K0050	What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice? An in-service was conducted with the maintenants staff to ensure fire drills performed are unexpected and are at least conducted quarted on each shift. How will you identify other residents have the potential to be affected the same deficient practice what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. We measures will be put into place what systemic changes will you make to ensure that the deficient practice does not recur? Fire	en s ince nd erly ring by and be ne e Vhat ce or ou sient

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Event ID: VS5Z21 Facility ID:

000012

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029		A. BUILDING	O1	(X3) DATE COMPI 05/02/2	ETED	
	PROVIDER OR SUPPLIER		5600	ET ADDRESS, CITY, STATE, ZIP CODE EAST 16TH STREET ANAPOLIS, IN46218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
	conducted but ac documentation of available for revisions. 3.1-19(b) 2. Based on record the facility failed drills at unexpect conditions for 4 of deficient practice the facility include visitors. Findings include Based on review Report" document Maintenance Dir 11:30 a.m. on 05 drills conducted and 02/24/11 weep.m. and third shon 05/14/10, 10/10 conducted, resperation a.m. and 5:00 a.m. the time of record Maintenance Dir second and third	ord review and interview, to conduct quarterly fire ted times under varying of 4 quarters. This e affects all occupants in ding residents, staff and the ding residents, staff and the ector from 9:45 a.m. to //02/11, second shift fire on 06/16/10, 07/30/10 are each conducted at 3:05 iff fire drills conducted 15/10 and 03/11/11 were ctively, at 5:10 a.m., 5:10 a.m., 5:10 a.m. Based on interview at d review, the ector acknowledged shift fire drills were not expected times under		schedule was developed ensure fire drills conduct unexpected times and un varying conditions. How corrective action(s) be monitored to ensure the deficient practice will not i.e., what quality assurate program will be put into the CQI Committee with the results of the fire drill compliance. If compliance achieved, an action plant developed to ensure corrective actions are considered to ensure corrective.	eed are at ender w will the e ot recur, ance o place? will review ls for ce is not will be	

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029		(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/02/2011		
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5600 EAST 16TH STREET INDIANAPOLIS, IN46218				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0144 SS=F	exercised under lo month in accordar 3.4.4.1. 1. Based on recording the facility failed written record of the starting batter generator was may weeks. Chapter a requires storage lo connection with a systems shall be not more than 7 cmaintained in full manufacturer's spatteries shall be immediately upo Furthermore, NF checking storage electrolyte levels than 7 days. Charequires a writter performance, exercipairs for the gemaintained and a having jurisdiction.	ord review and interview, to ensure a complete weekly inspections of ries for the emergency aintained for 1 of 52 3-4.4.1.3 of NFPA 99 batteries used in essential electrical inspected at intervals of days and shall be 1 compliance with pecifications. Defective repaired or replaced in discovery of defects. PA 110, 6-3.6 requires batteries, including at intervals of not more exper 3-5.4.2 of NFPA 99 in record of inspection, ercising period, and inerator to be regularly vailable by the authority on. This deficient fect all residents, staff	K	0144	What corrective action(s) we be accomplished for those residents found to have be affected by the deficient practice? The emergency generator has been tested to ensure it turns on within ten seconds of power outage. In-service was conducted wi Maintenance staff to ensure emergency generator is che weekly. How will you ident other residents having the potential to be affected by same deficient practice and what corrective action will taken? All residents have to potential to be affected by the alleged deficient practice. In measures will be put into por what systemic changes you make to ensure that the deficient practice does not recur? Maintenance staff we in-serviced by the Executive Director on assuring that emergency generator turns of within ten (10) seconds of a power outage. Maintenance within ten absence of Maintenance Director. Maintenance Director. Maintenance	en (10) the cked tify the e What lace will e /as	05/27/2011

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		O1 COMPLETED			(X3) DATE SURVEY		
AND PLAIN	OF CORRECTION	155029		A. BUILDING		05/02/2011	
		100020	B. WIN		DDDEGG CITY CTATE ZID CODE	00/02/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE AST 16TH STREET		
COMMUI	NITY NURSING AN	D REHABILITATION CENTER		1	APOLIS, IN46218		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
IAG		review of "Emergency	-	IAG	Director/designee will check	DATE	
		kly Inspection Checklist"			emergency generator 1 x we	ekly	
		with the Maintenance			to ensure it turns on within 10		
		45 a.m. to 11:30 a.m. on			seconds of power outage.		
		generator checklist			the corrective action(s) will monitored to ensure the	be	
		or the week of 04/12/11			deficient practice will not re	ecur,	
	stated "Vacation"				i.e., what quality assurance		
	documentation. Based on interview at the time of record review, the Maintenance Director stated no storage battery check of the emergency generator was conducted the week of 04/12/11 because he was on				program will be put into pla		
					The CQI committee will revie the results of the emergency		
					generator tests. If compliance		
					not achieved, an action plan will	will	
					be developed to ensure		
	vacation and acknowledged no weekly				compliance.		
		rator documentation was					
		week of 04/12/11.					
	3.1-19(b)						
		rview and record review,					
	I -	to ensure emergency					
	power would be						
		rator within 10 seconds of					
	· · ·	oss for 2 of 12 months.					
	· ·	1.8 states generator set(s)					
		ent capacity to pick up					
		t the minimum frequency					
	_	lity requirements of the					
	1	m within 10 seconds after					
	_	ower. NFPA 99, 3-5.4.2					
	_	n record of inspection,					
	_	ercising period and egularly maintained and					
		· ·					
	_	pection by the authority on. This deficient					
	naving jurisuiction	on. This deficient					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED 05/02/2011				
		155029	B. WIN	G		05/02/2	011
NAME OF I	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE		
0014141		D DELLA DII ITATIONI OENITED		1	AST 16TH STREET		
СОММО	COMMUNITY NURSING AND REHABILITATION CENTER			INDIAN	APOLIS, IN46218		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
	practice could affect all residents, staff and visitors.						
	and visitors.						
	Findings include	:					
		•					
	Based on record	review of "Emergency					
	Generator - Weel	kly Exercise/Monthly					
	Load Test Log" o	documentation with the					
		ector from 9:45 a.m. to					
		/02/11, monthly load test					
	documentation for 01/04/11 lists the						
		4.0 minutes and monthly					
		entation for 02/01/11 lists					
		as 8:50. Based on					
		ime of record review, the					
		rector stated when the					
		rator is in test mode it					
		ir minutes to transfer					
	_	ergency generator but in					
		of power to the building, ten seconds to transfer					
	l -	ergency generator. The ector acknowledged					
		t documentation for					
		01/11 did not state the					
		s less than 10 seconds.					
	transier time was	, 1035 than 10 Seconds.					
	3.1-19(b)						